DEPARTMENT OF HEALTH AND HUMAN SERVICES

LETTER OF NOTIFICATION - APPROVAL
Medically Indigent Assistance Program

Section I

Date _____

Name and Address of the Responsible Party

Section II

HOSPITAL CLAIM INFORMATION

This section must be completed for all approved applications.

Authorization Number: _____
County of Residence: _____
Gross Family Income: _____
Family Size: _____
Excess resources paid to hospital $ _____
Social Security Number/Unique Patient Identifier _____

Re: _____
Patient's Name

Name and Address of the County Designee

Readmission within 30 days? ☐ Yes ☐ No

Name of Hospital _____
Insurance Company

Policy Number(s)

Phone Number: _____

Section III – PLEASE READ THIS SECTION CAREFULLY FOR INFORMATION ABOUT YOUR APPLICATION FOR ASSISTANCE THROUGH THE MEDICALLY INDIGENT ASSISTANCE PROGRAM (MIAP).

S. C. general hospitals are required to provide unreimbursable services to persons who are determined eligible through MIAP.

Your application for assistance through the MIAP for the period of hospitalization beginning _____ has been approved based on verification that your income and resources were within program guidelines.

☐ Because your gross family income is equal to or less than 100% of the poverty guidelines, you will not be required to pay the hospital for any charges other than those which are not covered by the MIAP.

☐ Because your gross income is between 100% and 200% of the poverty guidelines, you **may be** required to make a payment on your hospital bill. The co-payment amount is $_____.

The hospital will not provide services to you free of charge and/or will hold you responsible for payment if:

1. The amount of your co-payment (based on your income) plus any insurance payments was more than the MIAP allowed amount.
2. Your inpatient hospital services/procedures were not medically necessary. Someone other than your doctor will review your medical record to decide if your admission was medically necessary.

Services provided by a doctor while you are in the hospital are not covered by the program. Such services include, but are not limited to, the reading of x-rays, checking of lab work, surgeon's fees, and visits by your doctor.

Reconsideration

If you do not agree with the action taken on your application, you may request a reconsideration through your county government. This request must be made in writing within thirty (30) days of the date of this letter and be directed to:

_____ at _____
(Name) (Address)

Telephone Number _____

Fair Hearing

If you disagree with the reconsideration decision, you may request a fair hearing before the Department of Health and Human Services. You may represent yourself at the hearing, hire an attorney to help you or have someone speak on your behalf. You must submit a written request for a hearing no later than 30 calendar days from the date on the reconsideration notice. In your requset, specifically state which issue(s) you wish to appeal. Submit your written request by one of the following methods:

Mail to:	Email:	Online:	Fax:
SCDHHS - Central Mail Post Office Box 100101 Columbia, SC 29202-3101 Attn: Eligibility Appeals	eligappeals@scdhhs.gov	www.scdhhs.gov/appeals	888-835-2086

DHHS-227 (Rev.9/2016)

MIAP Workers: Please provide a photocopy to the hospital and designee, if applicable.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact Janet Bell, ADA and Civil Rights Official, by mail at: PO Box 8206, Columbia, SC 29202-8206; by phone at: 1-888-549-0820 (TTY: 1-888-842-3620); or by email at: civilrights@scdhhs.gov.

If you believe that SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person or by mail or email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Language Services

If your primary language is not English, language assistance services are available to you, free of charge. Call: 1-888-549-0820 (TTY: 1-888-842-3620).

si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-549-0820 (TTY: 1-888-842-3620).

أذا كانت لغتك الاساسية غير اللغة الانكليزية فان خدمات المساعدات اللغوية متوفرة لك مجانا.اتصل على الرقم:

888-549-0280(رقم هاتف الصم والبكم 1-888-842-3620)

Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-549-0820 (TTY: 1-888-842-3620).

Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-549-0820 (телетайп: 1-888-842-3620).

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-549-0820 (TTY: 1-888-842-3620).

Se você fala português do Brasil, os serviços de assistência em sua lingua estão disponíveis para você de forma gratuita. Chame 1-888-549-0820 (TTY : 1-888-842-3620)

如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-549-0820 (TTY: 1-888-842-3620)

Falam tawng thiam tu na si le tawng let nak asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in na ko thei.

धयद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-888-549-0820 (TTY: 1-888-842- 3620) पर कॉल कर।

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-549-0820 (TTY: 1-888-842-3620)번으로 전화해 주십시오.

Haka tawng thiam tu na si le tawng let asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in ko thei.

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-549-0820 (ATS : 888-842-3620).

နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့်၊ ကျိာ်အတၱ်မၤစၢၤလၢ တလာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 888-549-0820 (TTY: 888-842-3620)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-549-0820 (መስማት ለተሳናቸው: 1-888-842-3620).

အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့် င့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 888-549-0820 (TTY: 888-842-3620) သို့ ခေါ် ဆိုပါ။